Your Benefits Your Move

Summary 2002

CITY OF LONG BEACH

TO CITY OF LONG BEACH EMPLOYEES

As a new Plan Year approaches, I encourage you to take this opportunity to *get in the game* and prepare yourself to make new benefit choices for 2002. This year's program theme – *Your Benefits. Your Move.* – emphasizes your role in the benefits decision-making process. It's up to you to take the time to develop a winning strategy as well as a solid understanding of your benefit options. Then, after carefully assessing your own personal needs, make your move to the plans that will work best for you and your family.

Some things have changed for 2002. Rising health care costs are an ongoing challenge to the City when it comes to providing quality medical plans for our employees. To deal with the increasing costs, the City had to take corrective action. As a result, you will see higher payroll deductions for some medical plan options. Plan copayments, including your cost for prescriptions, have also increased.

You will see the greatest cost increase with the PPO High Plan, as this Plan is the most expensive for the City to provide. As an affordable alternative, the City is pleased to introduce the PPO Value Plan. If you currently participate in the PPO High Plan, I encourage you to consider the PPO Value Plan. Your payroll deductions will be lower, and you will continue to receive comprehensive medical coverage. If your cost for coverage is a concern and you live in the Long Beach area, consider the Long Beach Choice POS Plan. This Plan requires no monthly payroll deductions and offers a high level of coverage.

This Summary Booklet describes the benefit changes for 2002 and provides an overview of the many benefit choices available to you. Please take the time to read this booklet thoroughly and make your selections carefully. The choices you make during this open enrollment will be effective from December 1, 2001 through November 30, 2002.

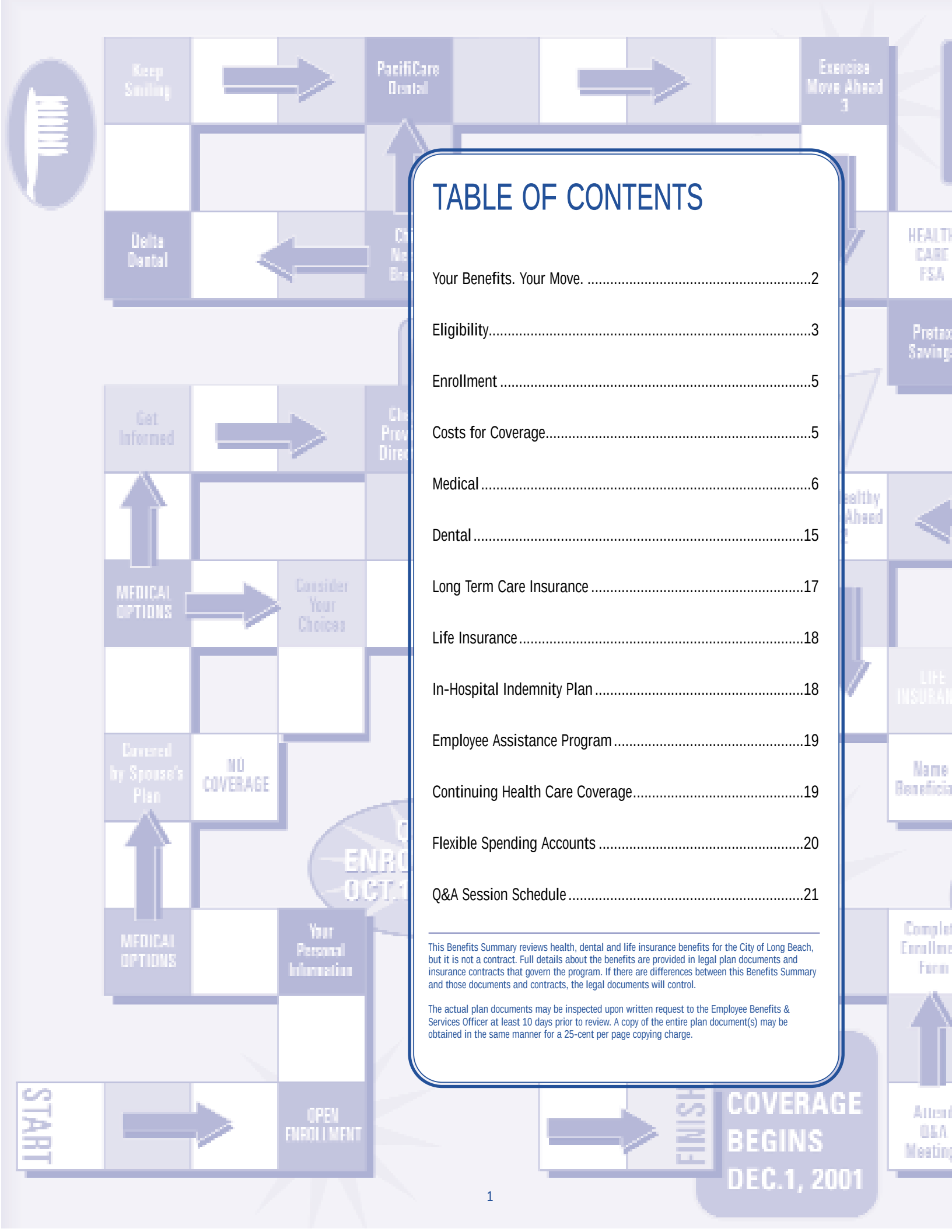
You and your family are encouraged to attend one of the Question and Answer sessions offered during open enrollment. The dates, times and locations are listed at the back of this Summary Booklet.

The City makes every effort to ensure that our benefits program remains competitive and responsive to your needs. As we begin open enrollment, I hope you will take the time to review your new coverage options and make your move to the benefits that truly work for you. Please visit our intranet web site for more information. The address is http://wmirror. (Click on "HR Employee Page.")

Have a safe and healthy year.

Sincerely,

DEBORAH R. MILLS
Employee Benefits & Services Officer



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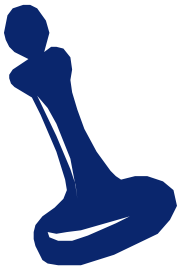
This Benefits Summary reviews health, dental and life insurance benefits for the City of Long Beach, but it is not a contract. Full details about the benefits are provided in legal plan documents and insurance contracts that govern the program. If there are differences between this Benefits Summary and those documents and contracts, the legal documents will control.

The actual plan documents may be inspected upon written request to the Employee Benefits & Services Officer at least 10 days prior to review. A copy of the entire plan document(s) may be obtained in the same manner for a 25-cent per page copying charge.



Your Benefits. Your Move

Selecting your own benefits requires strategic thinking. It's not a simple roll of the dice; so don't leave it to chance. Before you make your move you need to learn about the coverage options, analyze your personal situation, and decide what combination of benefits will work for you.

Your Benefits Summary is designed to make this process as easy as possible. The table below shows a list of the benefits available.

REVIEW YOUR BENEFIT MATERIALS

Take some time to review the benefit materials before making your choices. You'll soon discover it's well worth the effort!

A Place to Start

Medical coverage is perhaps the most important of your benefits. Not only does it help you maintain wellness, but it protects against major financial strain should you or a family member need extensive medical care. So choosing a medical plan is a good starting point. To help you pick the best plan for you, consider these questions:

- Is your current medical coverage meeting your needs?
- How much have you used medical coverage in the past? What types of services do you use?
- How much financial risk are you comfortable with?
- Do you like the concept of receiving all of your care from providers who belong to a network? Or do you want the freedom to visit other providers, even if you pay more?
- Would you like to choose your own physician when you receive treatment?

TYPE OF COVERAGE	OPTIONS	WHO CAN BE COVERED
Medical	• Long Beach Choice POS Plan • Great-West POS Plan • Great-West PPO Value Plan • Great-West PPO High Option Plan • Great-West PPO Low Option Plan • PacifiCare HMO Plan	You and your eligible dependents
Dental	• Delta Dental Plan • PacifiCare Dental Plan	You and your eligible dependents
Life Insurance	• $20,000 of insurance	You
In-Hospital Insurance	• In-Hospital Indemnity Plan, which pays additional benefits for hospitalization	You and your eligible dependents
Professional Counseling Services	• Employee Assistance Program (EAP)	You and your eligible dependents
Long Term Care	• Long Term Care Plan which provides financial help for care needed at home or in a nursing home when you cannot care for yourself	You and your eligible dependents

ELIGIBILITY

Following are the eligibility rules for the City's group insurance plans:

1. Employees must be permanent, full-time City employees. *Permanent* — A position in which the duties of the position are not expected to terminate at any given time. *Full-Time* — A position which normally requires an employee to work a forty-hour work week.
2. New employees hired on the first through fourth of the month are eligible on the first of the following month (i.e. hired July 1, eligible August 1).
3. New employees hired on or following the fifth of the month are eligible on the first of the month following or coinciding with one full month of employment (i.e. hired July 5, eligible September 1).

Upper Age Limit for Eligible Children

- The age limit for unmarried dependent children is age 19.
- The upper age limit for unmarried full-time students (dependent on their parents for at least half of their economic support) is through age 25. To maintain coverage for a student, a copy of the student's registration must be mailed or faxed to the insurance carrier each semester/quarter. When a student reaches age 26, coverage will terminate unless the student elects to enroll in COBRA.
- Unmarried children age 19 or over who are physically or mentally incapable of self-support may be continued under the health and dental care plans while remaining incapacitated, provided you continue your own coverage. To continue a child under this provision, the child must have been covered under the plan on the day before he or she would otherwise lose dependent status. Proof of incapacity must be provided within 30 days of the date the child would lose coverage (such as 30 days prior to turning age 19, losing full-time student status or turning age 26).

Adding New Dependents

Employees *must* complete the form to add new dependents within 30 days of becoming eligible. The effective date of coverage for new dependents may vary with each plan. A form to add new dependents and information regarding effective dates of coverage can be obtained from your Departmental Payroll/Personnel Assistant.

NOTE: If an employee does not complete the form to add the new dependent(s) within the required 30 days, the employee will not be able to add that dependent(s) until the next open enrollment period.

Eligible Dependents Include

- Legal spouse (a divorced spouse is not eligible)
- Unmarried natural children
- Unmarried step-children
- Domestic partners (same sex only)
- Disabled unmarried adult children
- Unmarried legally adopted children
- Unmarried foster children covered under legal custody.

NOTE: Mothers, fathers, grandparents, aunts, uncles, brothers, sisters, grandchildren, nephews, nieces, cousins, etc. are not eligible dependents. Legal custody for anyone other than a foster child(ren) does not make that person an eligible dependent.

Also, a divorced spouse is not eligible for continued coverage as a dependent under the employee's benefits program, even if the court orders the subscriber to provide coverage. Please refer to the COBRA rules (page 19) for information on coverage after a divorce.

Verification for Dependent Spouse

- Marriage license or certificate.

Verification for Domestic Partners

- *Certain qualification rules apply for domestic same sex partner coverage. Contact Human Resources for details.*

Verification for Dependent Children (one or more of the following)

- Birth or baptismal certificate
- Physician statement for disabled children
- Court orders for adoption
- Court orders for legal custody of foster children placed in a Certified Foster Home
- Final decree of divorce (requires only that portion which lists the names of dependents).

Please note that marriage certificates and birth certificates must have the state or county Certified Seal of where the event took place.

A certified marriage or birth certificate is issued by the State, County, or City Vital Statistics Office in accordance with federal guidelines. The document also has a traceable number. Birth certificates issued by hospitals are not official birth records and will not be accepted as proof of birth. Marriage certificates issued by a church or wedding chapel are not official marriage records and are not acceptable.

Official birth certificates can be obtained from the Long Beach Department of Health and Human Services for new babies born in the City of Long Beach.

Verification for Dependent Full-Time Student

- Any of the above verifying documents for dependent children and an appropriate federal tax return (requires only that portion which lists the names of the dependents). In addition, a copy of the student's registration must be mailed or faxed to the insurance carrier each semester/quarter.

PacifiCare of California
Attn: Student Status
5701 Katella Ave.
Cypress, CA 90630
Mail Stop CY24-515
Fax: (714) 226-5766

Great-West Life
PO Box 10188
Glendale, CA 92121
Fax: (818) 247-3597

City of Long Beach In-Hospital Indemnity Eligibility

Please obtain a plan brochure from your Departmental Payroll/Personnel Assistant.

Loss of Eligibility

An employee and/or his or her dependent(s) will lose the right of coverage when he or she is not in compliance with the eligibility rules. Thus, an individual is not covered as a result of termination, reduction in hours (less than full-time status), divorce, etc. It is the employee's responsibility to inform his or her Departmental Payroll / Personnel Assistant within 30 days of any event which would result in a status change. You must complete and return an enrollment form to delete dependents no longer eligible.

Continuation of benefits may be available through COBRA benefit provisions when health benefits would ordinarily terminate. In these cases, as well as in the event of a leave of absence or total disability, continuation of benefits may be available by self-paying the premiums (see page 19).

For more information regarding eligibility, loss of eligibility, or COBRA benefits, please see your Departmental Payroll/Personnel Assistant.

IF YOU DON'T WANT YOUR BENEFITS TO CHANGE

Check the box at the top of your enrollment form and return the form with your signature to your PPA.

If you wish to waive your health, dental and life benefits, you must complete a new "Waiver" form each year you do not want coverage.

ENROLLMENT

Open Enrollment

Open enrollment runs from October 1-12. You may enroll any time during this period. The benefits you elect will be effective for one year — from December 1, 2001, to November 30, 2002. If you don't return completed forms by October 12 at 4:30 p.m.:

- Your current medical and dental plan choices, covered dependents, and life insurance beneficiaries will automatically apply for the coming plan year.
- Your Departmental Payroll/Personnel Assistant will provide you with a preprinted form that shows your current medical and dental plan choices. If you wish to:
    - change your health plan;
    - change your dental plan;
    - add an eligible dependent(s);
    - delete a dependent(s); or
    - change your address

  please make your changes on this form.

Enrollment for New Employees

If you're hired on days 1-4 of the month, you become eligible for coverage on the first of the following month. If you're hired on or after day 5 of the month, eligibility for coverage starts on the first of the month following one full month of employment. You must complete an enrollment form and return it within 30 days of your of hire date. If you don't return your form by this deadline, you'll be automatically enrolled for:

- Coverage under the Great-West Low Option PPO Plan
- Coverage under the Delta Dental Plan
- Life insurance on yourself

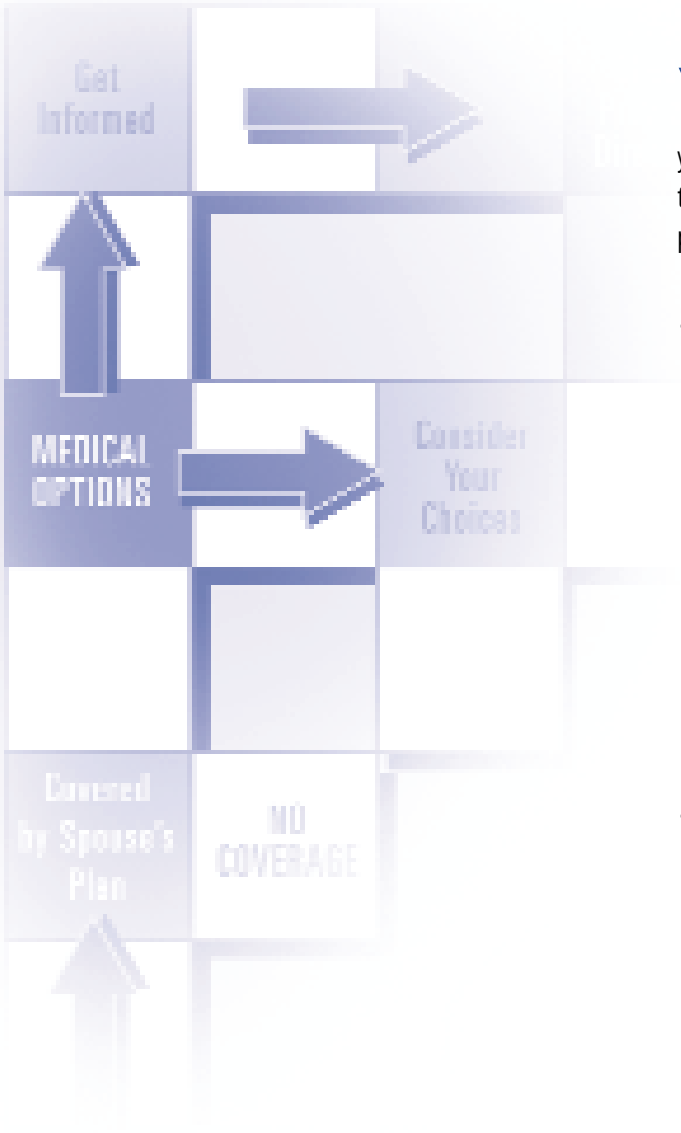
Your benefits will be effective until the next open enrollment period.

COSTS FOR COVERAGE

The City of Long Beach pays all — or most — of the cost for your medical and dental coverage and life insurance. You may have some contributions, depending on the plans you choose. Any contributions you have will be automatically deducted from your second paycheck each month.

This table shows what you pay for coverage each month, based on the combination of your medical and dental plans:

YOUR PLANS	YOUR MONTHLY PAYMENT
• Long Beach Choice POS Plan • Delta Dental Plan • Life Insurance	$0
• Long Beach Choice POS Plan • PacifiCare Dental Plan • Life Insurance	$0
• Great-West POS Plan • Delta Dental Plan • Life Insurance	$10
• Great-West POS Plan • PacifiCare Dental Plan • Life Insurance	$10
• Great-West PPO Value Plan • Delta Dental Plan • Life Insurance	$60
• Great-West PPO Value Plan • PacifiCare Dental Plan • Life Insurance	$25
• Great-West High Option PPO Plan • Delta Dental Plan • Life Insurance	$250
• Great-West High Option PPO Plan • PacifiCare Dental Plan • Life Insurance	$210
• Great-West Low Option PPO Plan • Delta Dental Plan • Life Insurance	$0
• Great-West Low Option PPO Plan • PacifiCare Dental Plan • Life Insurance	$0
• PacifiCare HMO Plan • Delta Dental Plan • Life Insurance	$54
• PacifiCare HMO Plan • PacifiCare Dental Plan • Life Insurance	$20



Pre-Tax Contributions

If the medical and dental coverages you choose require contributions, you have the advantage of paying them with pre-tax dollars. This means that your contributions are deducted from your paychecks before you pay Social Security taxes, federal income taxes, and most state and local income taxes. Deducting these payments lowers your taxable income, so your taxes are less. Thus, your take-home pay is higher than if you paid with after-tax dollars. If you're not already using this benefit, complete an enrollment form, available from your Departmental Payroll/Personnel Assistant.

MEDICAL

Your medical coverage should meet your needs as much as possible. That's why the City of Long Beach gives you six medical plans from which to choose. You can select the plan that best fits your health care situation and provides the financial protection you want.

There are three types of medical plans offered:

- *Point-of-Service (POS) Plans* — Included are the Long Beach Choice POS Plan and the Great-West POS Plan. A primary care physician (PCP), whom you choose at enrollment, oversees your medical care. He or she will refer you to specialists when necessary and arrange any hospitalization or surgery you need. Services rendered by a POS provider and approved by your PCP will be covered at the highest level—100% for most services. You have the freedom to obtain care without approval from your PCP, or to see a non-POS provider, but services are then covered at 50% of usual and customary, and claim forms are required.
- *Preferred Provider Option (PPO) Plans* — Included are the Great-West PPO Value Plan, Great-West PPO High Option and the Great-West PPO Low Option. The PPO network includes physicians, hospitals, and other types of health care providers. As long as you use any provider who belongs to the network, your care will be covered at the highest benefit level — generally 90% under the High Option, and 80% under the PPO Value Plan and Low Option, after the deductible. You may visit health care providers who are outside the network; if you do, benefits are paid at a lower level, and you must file claim forms.

  If you currently participate in the PPO High Plan, consider switching to the new PPO Value Plan. Your payroll deductions will be lower and you will continue to receive comprehensive coverage.

CHECK YOUR PROVIDER DIRECTORY

Because physicians can change their network participation, be sure to check your provider directory to make sure your current physician still serves the medical plan you choose.

INFORMATION AT YOUR FINGERTIPS

The City's intranet website is a great source for benefit plan and provider information. Visit us at http://wmirror (Click on "HR Employee Page.")

Other helpful sources for information include your provider directories and plan booklets. For plan representatives and phone numbers, refer to your "If You Have Questions" card.

- *Health Maintenance Organization (HMO) Plan* — PacifiCare is an HMO. At enrollment, you choose a participating medical group (PMG) and select a PCP from within that group to coordinate your health care. PacifiCare covers most medical services at 100%, as long as you use providers who belong to your PMG. Any care you receive without approval from your PCP or PMG is not covered. For emergency room services, you pay a $50 copay per visit. This copay is waived if you are admitted to the hospital. There are no claim forms required.

Mental Health Services

For Great-West Life Plans

When you are enrolled in any Great-West Life plan, your mental health benefits (including alcohol and chemical dependency) are provided by Associated Therapists, Inc. To receive services, call (714) 898-9858, 10:00 am-6:00 pm Monday through Friday. For emergencies call (714) 490-7083. You do not need a referral from your primary care physician to use these services. However, if you are out of Southern California and are a POS member, you should contact your PCP for a referral to a Mental Health Provider. If you are a PPO Member out of area, contact Great-West Life Member Services at (800) 766-3206 or visit the Great-West website at www.onehealthplan.com.

For PacifiCare Plans

The PacifiCare Plan includes coverage for Severe Mental Illness (SMI) for adults and children, Serious Emotional Disturbances (SED) of a child, and Chemical Dependency (CD) coverage provided through PacifiCare Behavioral Health Incorporated (PBHI).

Members and eligible dependents always have direct, around-the-clock access to behavioral health benefits. You do not need to go through your primary care physician for a referral and all services are completely confidential. Call (800) 999-9585.

Refer to your Schedule of Benefits for a list of covered services, copayments, exclusions, and limitations.

About the Health Care Provider Groups

Here are some things to keep in mind as you weigh your medical plan options:

- Consider the location of the PCP (for the POS plans and PacifiCare HMO) or the PPO network providers you may use. Your physician should be within a reasonable distance (about 30 miles) of your home or office.
- You must select a PCP if you enroll in one of the POS plans or PacifiCare. You may choose different PCPs for yourself and each of your family members, if you wish.
- The Long Beach Choice POS Plan is for employees who live or work in and around Long Beach, because the plan offers only providers who are predominantly located in that area.
- The network of chiropractors available to Great-West and PacifiCare members is called American Specialty Health Plans (ASHP). It features quality providers throughout California. You do not need a referral from your primary care physician to use these providers. However, if you do not use ASHP providers when you need care, benefits will be paid at the out-of-network rates. For help locating an ASHP provider, call (800) 678-9133.
- If you enroll yourself and family in the Long Beach Choice POS Plan but have a dependent who lives elsewhere (to attend school, for example), that dependent may participate in the Great-West POS Plan. You'll still pay nothing for your coverage, as long as you (the employee) remain in Long Beach Choice.
- The Great-West PPO plans have national networks of physicians and hospitals. Network providers are often available when you travel or if your dependents live in other areas.
- PacifiCare covers urgent and emergency services outside your service area when you travel, or for students who attend school full-time, minus the emergency room copayment.

Comparing Plan Benefits

This table summarizes benefits for each of the City's medical plans. Note that the Long Beach Choice POS Plan and Great-West Life POS Plan provide the same coverage. The payroll deduction, however, varies for each plan. (There is NO PAYROLL DEDUCTION for the Long Beach Choice POS Plan.) Plan year deductibles are the amount you pay each year (where applicable) before your plan begins paying benefits.

	Long Beach Choice POS & Great-West Life POS	Great-West PPO Value Plan	Great-West PPO High Plan	Great-West PPO Low Plan	PacifiCare of California High Plan PCP/PMG Approved Care Only***
Plan Year Deductible	***In-Network:*** $0 ***Out-of-Network:*** $200 individual $400 family	***In-Network:*** $200 individual $400 family ***Out-of-Network:*** $200 individual $400 family	***In-Network:*** $200 individual $400 family ***Out-of-Network:*** $200 individual $400 family	***In-Network:*** $300 individual $600 family ***Out-of-Network:*** $300 individual $600 family	$0
Lifetime Maximum	***In-Network:*** Unlimited ***Out-of-Network:*** $1,000,000	***In-Network:*** Unlimited ***Out-of-Network:*** $1,000,000	***In-Network:*** Unlimited ***Out-of-Network:*** $1,000,000	***In-Network:*** Unlimited ***Out-of-Network:*** $1,000,000	Unlimited
Covered Expense/ Out-of-Pocket Limit	***In-Network:*** Not applicable ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $20,000 of covered expenses (i.e., $4,000 of out-of-pocket expenses excluding deductibles and copayments) for each covered individual; limit of two per family ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $25,000 of covered expenses (i.e., $2,500 of out-of-pocket expenses excluding deductibles and copayments) for each covered individual; limit of two per family ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $100,000 of covered expenses (i.e., $20,000 of out-of-pocket expenses excluding deductibles and copayments) for each covered individual; limit of two per family ***Out-of-Network:*** No limit	$1,000 annual copay maximum per individual (limit of three per family)
Hospitalization	***In-Network:*** 100% ***Out-of-Network:*** 50%* up to covered daily maximum of $300 ($150 a day paid maximum)	***In-Network:*** 80%* ***Out-of-Network:*** You pay $500 per confinement, then covered at 60%* up to $300 per day ($180 paid maximum per day)	***In-Network:*** 90%* ***Out-of-Network:*** You pay $200 per confinement, then covered at 70%* up to $300 per day ($210 paid maximum per day)	***In-Network:*** You pay $200 per confinement, then covered at 80%* ***Out-of-Network:*** You pay $500 per confinement, then covered at 60%* up to $300 per day ($180 paid maximum per day)	Semi-private room or ICU with ancillary services covered in full for unlimited days (includes SMI benefits mandated by AB88)
Hospital Preadmission Tests	***In-Network:*** 100% ***Out-of-Network:*** 50%*	***In-Network:*** 100% ***Out-of-Network:*** 100%	***In-Network:*** 100% ***Out-of-Network:*** 100%	***In-Network:*** 100% ***Out-of-Network:*** 100%	100%**
Inpatient & Outpatient Surgery	***In-Network:*** 100% ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	100%**
Physician Charges for Hospital Care & Surgery	***In-Network:*** 100% ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	100%**
Emergency Room	***In-Network:*** 100% after you pay $50. Payment waived if hospitalization follows. If possible, contact your PCP for instructions. Otherwise, seek treatment at the nearest facility, then contact your PCP within 48 hours in order for you to receive highest plan benefits. ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	$50 copayment per visit. Waived if admitted to the hospital.

* Paid after the deductible

**Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group).

***PCP is your Primary Care Physician

	Long Beach Choice POS & Great-West Life POS	Great-West PPO Value Plan	Great-West PPO High Plan	Great-West PPO Low Plan	PacifiCare of California High Plan PCP/PMG Approved Care Only**
Physician Office Visits	***In-Network:*** You pay $15 at the time of visit, then covered at 100% ***Out-of-Network:*** 50%*	***In-Network:*** You pay $20 at the time of visit, then covered at 100% ***Out-of-Network:*** 60%*	***In-Network:*** You pay $20 at the time of visit, then covered at 100% ***Out-of-Network:*** 70%*	***In-Network:*** You pay $25 at the time of visit, then covered at 100% ***Out-of-Network:*** 60%*	$10 copayment per visit
Outpatient X-ray & Laboratory	***In-Network:*** 100% ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	100%**
Maternity Care	***In-Network:*** 100% ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	Covered in full except for certain elective procedures, which are subject to copays.
Birthing Centers	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** 100% (24-hour stay starting at child's birth)	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** 100% (24-hour stay starting at child's birth)	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** 100% (24-hour stay starting at child's birth)	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** 100% (24-hour stay starting at child's birth)	100%**
Adult Physical & Routine Well-Baby Care	***In-Network:*** You pay $15 at the time of visit, then covered at 100% Women can self refer for one annual OB/GYN visit within their doctor's managed physician group. ***Out-of-Network:*** 50%* up to $250 per year	***In-Network:*** You pay $20 at the time of visit, then covered at 100% up to $250 per year ***Out-of-Network:*** 60%* up to $250 per year	***In-Network:*** You pay $20 at the time of visit, then covered at 100% up to $250 per year ***Out-of-Network:*** 70%* up to $250 per year	***In-Network:*** You pay $25 at the time of visit, then covered at 100% up to $250 per year ***Out-of-Network:*** 60%* up to $250 per year	Covered in full after $10 copayment. (Waived for Well-Baby Care for children under 2) Limited to one exam each calendar year
Prescription Drugs	***In-Network:*** When you use a PCS pharmacy: $5 generic; $15 brand. Mail order services available. ***Out-of-Network:*** When you use a non-PCS pharmacy, you must file a claim form directly with PCS; the benefit amount paid will be reduced.	***In-Network:*** When you use a PCS pharmacy: $5 generic; $15 brand. Mail order services available. ***Out-of-Network:*** When you use a non-PCS pharmacy, you must file a claim form directly with PCS; the benefit amount paid will be reduced.	***In-Network:*** When you use a PCS pharmacy: $5 generic; $15 brand. Mail order services available. ***Out-of-Network:*** When you use a non-PCS pharmacy, you must file a claim form directly with PCS; the benefit amount paid will be reduced.	***In-Network:*** When you use a PCS pharmacy: $5 generic; $15 brand. Mail order services available. ***Out-of-Network:*** When you use a non-PCS pharmacy, you must file a claim form directly with PCS; the benefit amount paid will be reduced.	$5 generic, $15 brand; $25 non-formulary; for 30-day supply Open formulary Mail order services available – $10 generic; $30 brand; $50 non-formulary for 90 day supply
Chiropractic Care	***In-Network:*** Self-referral benefit no PCP approval required. If you use ASHP network chiropractors, plan pays 100% of contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Self-referral benefit no PCP approval required. If you use non-network chiropractor, plan pays 50% of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year	***In-Network:*** When you use ASHP network chiropractors, plan pays 100%* of contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year	***In-Network:*** When you use ASHP network chiropractors, plan pays 100%* of contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year	***In-Network:*** When you use ASHP network chiropractors, plan pays 100%* of contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year	$10 copayment; 40 visits (combined with acupuncture) per year through ASHP provider

* Paid after the deductible

**Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group).

***PCP is your Primary Care Physician

	Long Beach Choice POS & Great-West Life POS	Great-West PPO Value Plan	Great-West PPO High Plan	Great-West PPO Low Plan	PacifiCare of California High Plan PCP/PMG Approved Care Only**
Acupuncture	***In-Network:*** 50% of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum	$10 copayment; 40 visits (combined with chiropractic) per year through ASHP provider
Durable Medical Equipment (DME)	***In-Network:*** With approval from your PCP, the plan pays 100% when you rent or purchase DME from a contracted facility ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	100%**
Hearing Aids	***In-Network:*** 100% up to $1,000 every 3 years ***Out-of-Network:*** 50%* up to $1,000 every 3 years	***In-Network:*** 80%* up to $1,000 every 3 years ***Out-of-Network:*** 60%* up to $1,000 every 3 years	***In-Network:*** 90%* up to 1,000 every 3 years ***Out-of-Network:*** $70%* up to $1,000 every 3 years	***In-Network:*** 80%* up to $1,000 every 3 years ***Out-of-Network:*** 60%* up to $1,000 every 3 years	100%; limit of one for each ear in a 3-year period** (hearing exam covered in full after $10 copay)
Orthotics	***In-Network:*** 100% up to $75 every 3 years ***Out-of-Network:*** 50%* up to $75 every 3 years	***In-Network:*** 80%* up to $75 every 3 years ***Out-of-Network:*** 60%* up to $75 every 3 years	***In-Network:*** 90%* up to $75 every 3 years ***Out-of-Network:*** 70%* up to $75 every 3 years	***In-Network:*** 80%* up to $75 every 3 years ***Out-of-Network:*** 60%* up to $75 every 3 years	Not covered
Inpatient Mental Health & Substance Abuse Treatment	***In-Network:*** 100%; 30-day plan year benefit; 60 days lifetime ***Out-of-Network:*** 50%* covered up to a $300 per day maximum ($150 per day paid benefit); 30-day plan year benefit; 60 days lifetime	***In-Network:*** 80%* up to $15,000 per plan year for all inpatient care ***Out-of-Network:*** You pay $500 per confinement. Then covered at 60%* up to $300 per day ($180 paid maximum per day) $15,000 per plan year maximum for all inpatient care	***In-Network:*** 90%* up to $15,000 per plan year for all inpatient care ***Out-of-Network:*** You pay $200 per confinement. Then covered at 70%* up to $300 per day ($210 paid maximum per day) $15,000 per plan year maximum for all inpatient care	***In-Network:*** You pay $200 per confinement. Then covered at 80%* up to $15,000 per plan year for all inpatient care ***Out-of-Network:*** You pay $500 per confinement. Then covered at 60%* up to $300 per day ($180 paid maximum per day) $15,000 per plan year maximum for all inpatient care	Covered in full for unlimited days; members must access PacifiCare Behavioral Health Network. (Substance abuse subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined)
Outpatient Mental Health & Substance Abuse Benefits	***In-Network:*** You pay $15 per visit, then coverage at 100%, 20 visits per plan year maximum benefit for all outpatient care. **Self-Referral Restriction:** You can only self refer to an Associated Therapists provider to receive in-network benefits. See your handbook for details. ***Out-of-Network:*** 50%*; 20 visits per plan year maximum benefit for all outpatient care	***In-Network:*** You pay $20 per visit. Then psychologists are covered at 100%; psychiatrists are covered up to $75 per visit.$1,500 plan year maximum for all outpatient care. ***Out-of-Network:*** 60%* covered up to $75 per visit ($45 paid). * $1,500 plan year maximum for all outpatient care	***In-Network:*** You pay $20 per visit. Then psychologists are covered at 100%; psychiatrists are covered up to $75 per visit. $2,000 plan year maximum for all outpatient care ***Out-of-Network:*** 70%* covered up to $75 per visit. $2,000 plan year maximum for all outpatient care.	***In-Network:*** You pay $25 per visit. Then psychologists are covered at 100%; psychiatrists are covered up to $75 per visit. $1,500 plan year maximum for all outpatient care. ***Out-of-Network:*** 60%* covered up to $75 per visit ($45 paid). $1,500 plan year maximum for all outpatient care	Covered in full after $10 copayment per visit for mental health; unlimited visits. Covered at 100% for substance abuse; subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined. Members must access PacifiCare Behavioral Health Network

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

	Long Beach Choice POS & Great-West Life POS	Great-West PPO Value Plan	Great-West PPO High Plan	Great-West PPO Low Plan	PacifiCare of California High Plan PCP/PMG Approved Care Only***
Lifetime Maximum Benefit for Mental Health & Substance Abuse Treatment	***In-Network:*** 60-day maximum for all inpatient care ***Out-of-Network:*** Same as In-Network	***In-Network:*** $50,000 for all inpatient & outpatient care ***Out-of-Network:*** Same as In-Network	***In-Network:*** $50,000 for all inpatient & outpatient care ***Out-of-Network:*** Same as In-Network	***In-Network:*** $50,000 for all inpatient & outpatient care ***Out-of-Network:*** Same as In-Network	Unlimited, except as noted above for substance abuse
Skilled Nursing Facilities (SNF)	***In-Network:*** 100% Limited to 90 days per plan year ***Out-of-Network:*** 50%* Limited to 90 days per plan year	***In-Network:*** 80%* Limited to 90 days per plan year ***Out-of-Network:*** 60%* up to $90 per day; limited to 90 days per plan year	***In-Network:*** 90%* Limited to 90 days per plan year ***Out-of-Network:*** 70%* up to $105 per day Limited to 90 days per plan year	***In-Network:*** 80%* Limited to 90 days per plan year ***Out-of-Network:*** 60%* up to $90 per day Limited to 90 days per plan year	100% up to 100 consecutive days from first treatment per disability
Home Health	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** 50%*	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** Same as In-Network	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** Same as In-Network	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** Same as In-Network	100%**
Hospice Care	***In-Network:*** 100% ***Out-of-Network:*** 50%* (some limits apply)	***In-Network:*** 100% ***Out-of-Network:*** 100%	***In-Network:*** 100% ***Out-of-Network:*** 100%	***In-Network:*** 100% ***Out-of-Network:*** 100%	Covered in full (up to 180 days per lifetime)

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

Vision Care

Vision care for the Great-West Life POS and PPO plans is provided through a network of eye care professionals called Medical Eye Services (MES). Eye exams are covered in full when you use an MES optometrist or ophthalmologist. If you participate in the PacifiCare HMO, eye exams, standard frames and lenses are covered in full once every 12 months if you use an MES eye care professional. However, to receive 100% coverage for eyeglasses, you must get your glasses from an MES store.

	Participating MES Provider Plan Pays…	Non-Participating Provider Plan Pays…
Exams	100%	$57.50 for optometrist $67.50 for ophthalmologist
Single vision lenses	100%*	$45
Bifocal lenses	100%*	$63
Trifocal lenses	100%*	$80
Frames	Up to $60	Up to $40
Contact lenses (cosmetic)	$100	$100
* Must be medically necessary; anything for cosmetic purposes is extra.		

COMPARING PLAN RULES

It's important that the benefits offered by your medical plan meet your health care needs. But when selecting the plan that's right for you, you should also be comfortable with the plan's "rules." The following questions and answers show differences in how the plans operate.

Question: How should I weigh my payroll contributions for coverage with the benefits I get from the plan?

Long Beach Choice POS Plan and Great-West POS Plan
Payroll deduction is $0 for the Long Beach Choice POS Plan and $10 monthly for the Great-West POS Plan. Most services are covered at 100% if your PCP approves care and the services are rendered by a POS provider. Physician office visits are covered at 100% after a $15 copay.

Great-West PPO Value Plan
If you have Delta Dental you pay $60 monthly. You pay only $25 a month for coverage with PacifiCare Dental. Most services are covered at 100% if your PCP approves care and the services are rendered by a POS provider. Physician office visits are covered at 100% after you pay $20 each time you visit the physician.

Great-West PPO High Option Plan
If you have Delta Dental, you pay $250 a month; with PacifiCare Dental you pay $210 a month for coverage. In return, most services you receive from network providers are covered at 90% after deductible. Physician office visits are covered at 100% after your $20 copay.

Great-West PPO Low Option Plan
Payroll deduction is $0. Most services you receive from network providers are covered at 80% after deductible. Physician office visits are covered at 100% after you pay $25 each time you visit the physician.

PacifiCare HMO Plan
If you have Delta Dental, you pay $54 a month; with PacifiCare Dental you pay $20 a month for coverage. In return, most services you receive are covered at 100% if your PCP approves care. Visits to your physician have a $10 copay.

Question: What must I do to get the highest plan benefits?

Long Beach Choice POS Plan and Great-West POS Plan
Make sure that your PCP approves all of your medical care and refers you to a participating POS provider.

Great-West PPO Value Plan
Make sure you use physicians, hospitals, and other providers who belong to the extensive PPO network.

Great-West PPO High Option Plan
Make sure you use physicians, hospitals, and other providers who belong to the extensive PPO network.

Great-West PPO Low Option Plan
Make sure you use physicians, hospitals, and other providers who belong to the extensive PPO network.

PacifiCare HMO Plan
Make sure that your PCP approves all of your medical care and that you receive care from providers within your participating medical group (PMG).

COMPARING PLAN RULES

Question: Do I have the option to visit any physician of my choice?

Long Beach Choice POS Plan and Great-West POS Plan	Great-West PPO Value Plan	Great-West PPO High Option Plan	Great-West PPO Low Option Plan	PacifiCare HMO Plan
Yes. If you obtain care not approved by your PCP, most services are covered at 50% usual and customary (U&C) after deductible.	Yes. If you use out-of-network providers, most services are covered at 60% after deductible.	Yes. If you use out-of-network providers, most services are covered at 70% after deductible.	Yes. If you use out-of-network providers, most services are covered at 60% after deductible.	No. However, you may change your PMG during open enrollment, if you move, or once each month for any reason.

Question: What if I need emergency care or care away from home?

Long Beach Choice POS Plan and Great-West POS Plan	Great-West PPO Value Plan	Great-West PPO High Option Plan	Great-West PPO Low Option Plan	PacifiCare HMO Plan
If possible, contact your PCP for instructions. Otherwise, seek treatment at the nearest facility, then contact your PCP within 48 hours. Your PCP must authorize this treatment in order for you to receive highest plan benefits.	If possible, call Great-West at 1-800-766-3206 and ask if there is a PPO facility in the area. Otherwise, seek treatment at the nearest facility. Any care received out-of-network will be covered at 60% after deductible.	If possible, call Great-West at 1-800-766-3206 and ask if there is a PPO facility in the area. Otherwise, seek treatment at the nearest facility. Any care received out-of-network will be covered at 70% after deductible.	If possible, call Great-West at 1-800-766-3206 and ask if there is a PPO facility in the area. Otherwise, seek treatment at the nearest facility. Any care received out-of-network will be covered at 60% after deductible.	Call 911 or seek treatment at the nearest emergency facility. Contact your PCP within 48 hours, or when reasonably possible.

Question: Is pre-treatment authorization necessary before hospitalization or surgery?

Long Beach Choice POS Plan and Great-West POS Plan	Great-West PPO Value Plan	Great-West PPO High Option Plan	Great-West PPO Low Option Plan	PacifiCare HMO Plan
Your PCP must authorize your treatment, refer you to a POS provider, and call for precertification if you are hospitalized or have outpatient surgery and are in-network.	No authorization is necessary when you use PPO providers. However, if you're hospitalized or have surgery out-of-network, it's important that you call 1-800-766-3206 for preauthorization before your treatment, if possible, or within 48 hours following treatment. *If preauthorization is not obtained, you may pay an additional $500 fee which does not apply to your annual deductible.*	No authorization is necessary when you use PPO providers. However, if you're hospitalized or have surgery out-of-network, it's important that you call 1-800-766-3206 for preauthorization before your treatment, if possible, or within 48 hours following treatment. *If preauthorization is not obtained, you may pay an additional $500 fee which does not apply to your annual deductible.*	No authorization is necessary when you use PPO providers. However, if you're hospitalized or have surgery out-of-network, it's important that you call 1-800-766-3206 for preauthorization before your treatment, if possible, or within 48 hours following treatment. *If preauthorization is not obtained, you may pay an additional $500 fee which does not apply to your annual deductible.*	It is only necessary that your PCP authorize your treatment, unless an emergency condition exists as described above.

COMPARING PLAN RULES

Question: Do preexisting conditions apply?

Long Beach Choice POS Plan and Great-West POS Plan	Great-West PPO Value Plan	Great-West PPO High Option Plan	Great-West PPO Low Option Plan	PacifiCare HMO Plan
Yes. Please see the rules explained on page 15.	Yes. Please see the rules explained on page 15.	Yes. Please see the rules explained on page 15.	Yes. Please see the rules explained on page 15.	No.

Question: How can I cover my eligible dependents if they live away from me?

Long Beach Choice POS Plan	Great-West POS Value Plan	Great-West PPO High Option Plan	Great-West PPO Low Option Plan	PacifiCare HMO Plan
If your dependents don't live in Long Beach, they can select a Great-West POS Plan PCP where they live and receive the same benefits, or they can return to Long Beach and be treated by their family PCP. **Great-West POS Plan** Great-West has primary care physicians (PCPs) located around the nation. Your dependent may be able to select a PCP near where he or she lives to receive maximum plan benefits. If this is not possible, your dependent will be covered at the unapproved level.	Great-West has nationwide groups of PPO network providers. These providers may be located near your dependent, so he or she can receive maximum plan benefits. Otherwise, your dependent will be covered at the out-of-network level.	Great-West has nationwide groups of PPO network providers. These providers may be located near your dependent, so he or she can receive maximum plan benefits. Otherwise, your dependent will be covered at the out-of-network level.	Great-West has nationwide groups of PPO network providers. These providers may be located near your dependent, so he or she can receive maximum plan benefits. Otherwise, your dependent will be covered at the out-of-network level.	PacifiCare has participating medical groups (PMGs) around the state. Your dependent may select a PMG located within 30 miles of his or her home, as long as they live within an approved PacifiCare service area. If this is not possible, your dependent can't be covered under this plan.

Question: Do I have to complete claim forms?

Long Beach Choice POS Plan and Great-West POS Plan	Great-West PPO Value Plan	Great-West PPO High Option Plan	Great-West PPO Low Option Plan	PacifiCare HMO Plan
Not if your care is approved by your PCP. But you must complete claim forms for reimbursement of unapproved care.	Not if you receive care from PPO network providers. But you must complete claim forms for reimbursement of out-of-network services.	Not if you receive care from PPO network providers. But you must complete claim forms for reimbursement of out-of-network services.	Not if you receive care from PPO network providers. But you must complete claim forms for reimbursement of out-of-network services.	No. However, if you receive urgent or emergent treatment outside of your service area, you must submit your bills to PacifiCare's Members Services Department.

Preexisting Conditions

A preexisting condition is an illness, injury, or pregnancy for which you or your dependent received medical treatment within 90 days before your City medical coverage began. Your preexisting condition will not be covered until you participate in a City medical plan for six continuous months. These rules apply for:

- Newly hired employees (or rehired employees who didn't have COBRA) electing one of the POS plans or PPO plans
- Employees enrolling during open enrollment who have participated in the HMO Plan for less than six months and want to switch to one of the POS plans or PPO plans.

However, if you can provide a certificate proving you had health care coverage from another employer or carrier for six consecutive months before your City medical coverage began, your preexisting condition *will* be covered. (Or your preexisting period will be reduced one day for each day of continuous coverage (with no significant break of 63 or more days) just prior to your effective date of coverage under the PPO or POS plans.)

Preexisting condition rules do *not* apply for:

- Most employees enrolling during open enrollment (see the one exception above)
- Employees who choose the PacifiCare HMO Plan.

YOU MAY WAIVE YOUR MEDICAL COVERAGE

You have the option to waive medical coverage. To do so, you must complete a waiver form, available from your Departmental Payroll/Personnel Assistant. Note that if you decline medical coverage, you:

- May not participate in dental coverage or life insurance, and
- Must wait until the next open enrollment period to enroll for future medical coverage.

DENTAL

If you enroll in any one of the City's medical plans, you automatically receive dental coverage. You have a choice of two dental plans:

- *Delta Dental Plan* — This plan allows you to use any dentist of your choice. Your out-of-pocket costs are determined by the dentist you use — a Delta Preferred Option (DPO) dentist, Delta dentist, or an out-of-network dentist. It's to your advantage to select a Delta dentist or a dentist who participates in the Delta Dental Preferred Option (DPO) network. For care from DPO providers, you pay no deductible, and the plan pays a plan year maximum of $2,000.

  When you use a Delta dentist or an out-of-network dentist, you first pay a deductible. Then the plan pays a percentage of your costs up to $1,000 each plan year in covered benefits. However, by using one of the many Delta dentists throughout California, you will receive the advantage of a lower fee schedule than you would receive from an out-of-network dentist.

  With the Delta Dental Plan, you have the option to go to a specialist of your choice without preapproval, and you may change your dentist at any time without preapproval. Claim forms are required only if you receive care from out-of-network dentists.
- *PacifiCare Dental Plan* — When you enroll, you choose a dentist who belongs to the PacifiCare network of dental care providers. PacifiCare dentists are located in most areas of California. When you use the dentist you select at the time you enroll, most treatments are covered at 100%. However, if you use any other dentist, you receive no benefits. Each dependent may choose a different dentist, and claim forms are not required.

Comparing Plan Benefits

This table summarizes benefits under the dental plans. Refer to your employee handbook for coverage details.

PLAN BENEFITS	DELTA DENTAL PLAN		PACIFICARE DENTAL PLAN
	DPO Network	*Out-of-Network*	
Your Plan Year Deductible	$0	$50 individual $150 family	$0
Maximum Plan Year Benefit	$2,000 per person	$1,000 per person	$0
Preventive Treatment (oral examinations, teeth cleanings, x-rays)	100%*	100%** (deductible doesn't apply)	100%
Routine Treatment (fillings, extractions, treatment of gum disease)	80%*	80%**	100%
Major Treatment (crowns, bridges, dentures)	80%*	80%**	100%
Emergency Treatment	80%*	80%**	Contact your assigned dental office. If your condition prevents you from doing so, you must receive care from a licensed dentist. Your reimbursement will be subject to applicable copayments.
Dental Accident	100%	100% (deductible doesn't apply)	100%
Orthodontia	50%; $2,000 lifetime maximum for child; $1,000 lifetime maximum for adult	50% (deductible doesn't apply); $2,000 lifetime maximum for child; $1,000 lifetime maximum for adult	You pay up to $250 in start-up fees. You may be charged up to $500 for full bands or $250 for partial bands. A PCD orthodontist must provide treatment.
Preexisting Conditions	None	None	No coverage for dental procedures started before your participation in this plan.

** Based on DPO approved fees. ** Based on Delta Dental approved fees.*

YOU & YOUR DEPENDENTS MAY USE DIFFERENT DENTISTS

Under both dental plans, you and your dependents may use different dentists. When enrolling in PacifiCare Dental, simply choose the network dentist you want for each family member.

NEED MORE INFORMATION?

To learn more about the dental plans:

- Attend a Q&A session during open enrollment;
- Check Delta Dental's web page, or find Delta's information through the City's intranet address; or
- Ask your Departmental Payroll/Personnel Assistant for dental plan details.

LONG TERM CARE INSURANCE

The City of Long Beach is pleased to offer Long Term Care Insurance.

This plan provides financial help if you require care in a nursing facility, or at home, as a result of a loss of functional capacity or cognitive impairment due to injury, sickness, or advanced age.

Qualifying for benefits is based upon a need for assistance with any two of six activities of daily living including eating, bathing, dressing, toileting, continence, or transferring, and/or cognitive impairment such as dementia or Alzheimer's disease.

The basic plan provides $1000 of monthly benefits for up to three years in a facility.

Plan "Buy up Options" allow you to increase monthly benefits in units of $1000 up to $6000 monthly, and to add professional home care and inflation protection.

The plan is portable and can be taken with you if your employment discontinues or upon retirement.

The plan is also available to spouses, parents, grandparents, in-laws, part-time permanent employees, and retirees.

The younger you are, the lower the premium.

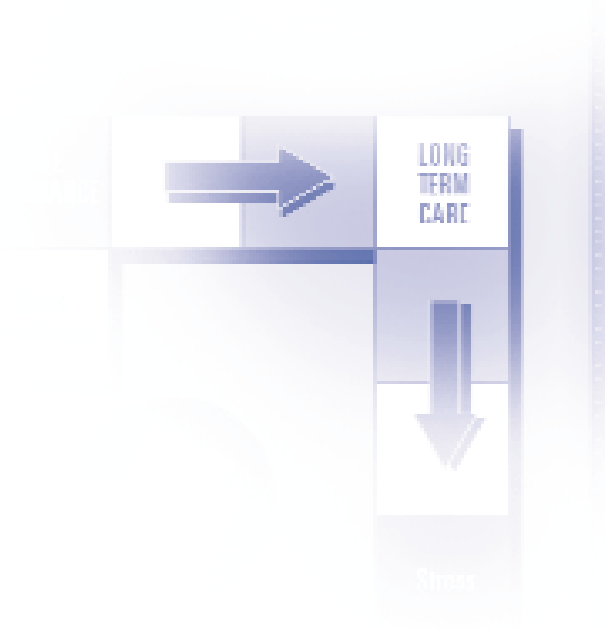
Premiums are based on age at time of enrollment and the level of benefits selected.

Employees who did not enroll in Long Term Care during the initial enrollment period, or within 30-days of their original hire date, may enroll during this Open Enrollment Period. However, the employee must complete a medical questionnaire to determine eligibility.

For more information, please see your Departmental Payroll/Personnel Assistant.

EXAMPLES OF MONTHLY RATES

	PLAN 1	PLAN 2 BASE PLAN WITH PROFESSIONAL HOME CARE	PLAN 3 BASE PLAN WITH COMPOUND INFLATION	PLAN 4 BASE PLAN WITH PROFESSIONAL HOME CARE COMPOUND INFLATION
AGE	BASE PLAN	OPTION	OPTION	OPTIONS
18-30	1.80	3.00	6.60	9.40
35	2.10	3.40	7.60	10.70
40	2.60	4.10	8.90	12.30
45	3.40	5.20	10.60	14.60
50	4.50	6.60	12.70	16.70
55	6.40	8.70	15.90	19.80
60	9.60	11.90	20.50	24.10
65	16.30	18.70	30.70	34.10
70	27.90	30.80	46.10	50.00



LIFE INSURANCE

Life insurance helps protect your family from a sudden loss of income in the event of your death. If you enroll in a City medical plan, you automatically receive $20,000 of life insurance for yourself.

You must complete a form designating your beneficiaries who will receive your life insurance should you die. You may change your beneficiaries at any time.

IF YOU ARE TERMINALLY ILL

If you're terminally ill, you may receive part of your life insurance while living. For more information, contact the Human Resources Department & Affirmative Action Department.

CITY OF LONG BEACH IN-HOSPITAL INDEMNITY PLAN

The City of Long Beach offers the In-Hospital Indemnity Plan, which pays benefits if you're hospitalized. Here's how it works:

- You receive $100 for each day you are in the hospital or $200 for each day you are in intensive care.
- This benefit is paid in addition to any other medical coverage you have.
- You may enroll yourself only or your dependents, too. New dependents, including newborns, must be enrolled within 30 days of eligibility. (See Eligibility on page 3).
- Claim forms are necessary for payment and must be submitted within 15 months of the date the claim was incurred.

Costs for Coverage

Your costs for the In-Hospital Indemnity Plan are based on your age and who you enroll, as shown in this table. Contributions are deducted from your paychecks once a month after taxes are withheld.

	MONTHLY COSTS			
YOUR AGE	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILDREN	ENTIRE FAMILY
Birth-34	$3.62	$ 6.90	$ 7.29	$10.58
35-44	4.38	8.39	8.06	12.07
45-54	5.92	11.30	9.59	14.97
55-59	7.45	14.25	11.12	17.92
60-64	7.68	14.63	10.42	17.37
65-69 (half benefit only)	4.38	8.39	6.58	10.59

Note: If you have been participating in this plan since March 1994 or earlier, you're not required to pay contributions for coverage this year.

EMPLOYEE ASSISTANCE PROGRAM

Life is not always easy. Problems arise that can affect us physically, emotionally, or spiritually. Sometimes it helps to talk things out.

The Employee Assistance Program (EAP) offers professional, confidential assistance with personal problems. The program is provided through the City's Department of Health and Human Services, and it is available to all City employees and their immediate family members. The EAP has trained counselors who can assist you with:

- Marriage or family relationships
- Work-related problems
- Financial or legal difficulties
- Stress, anxiety, or depression
- Alcohol or drug dependency
- Locating community resources, such as child daycare.

If your counselor thinks you should have further professional help, he or she will refer you to the services you need.

Be assured that your counseling is completely confidential. Your supervisor will not be aware of your participation unless you request it, and nothing about the EAP will be placed in your personnel file.

COBRA INFORMATION

Refer to your employee handbook or contact your Departmental Payroll/Personnel Assistant for more information about COBRA coverage, including when coverage ends.

CONTINUING HEALTH CARE COVERAGE

Under a law called the Consolidated Omnibus Budget Reconciliation Act (COBRA), you have the right to continue your medical and dental plan participation beyond when your City coverage would normally end. To do so, you must pay the full cost of medical and dental coverage, plus 2%.

The duration of continued coverage through COBRA depends on your situation (called a qualifying event), as follows:

- If your employment is terminated (for reasons other than gross misconduct) or your hours are reduced so that you are no longer eligible, you may continue health coverage for yourself and dependents for up to 18 months.
- If your dependent loses coverage because of divorce, legal separation, your death, or if your child reaches the maximum eligible age, that dependent may continue health coverage for up to 36 months.
- If you or your dependent becomes disabled (as defined by Social Security) before or within 60 days after starting COBRA coverage, the disabled person may have up to 29 months of COBRA coverage from the date he or she was first eligible. You must pay an additional amount for this extended coverage.

To obtain COBRA coverage, you must make a written request to your Departmental Payroll/Personnel Assistant within 60 days of:

- The end of the month in which your qualifying event occurs or
- Receiving notice from your supervisor of a qualifying event.

You will be asked to complete an enrollment form. Payments for COBRA coverage must be mailed to the City by the 20th of each month for the following month's coverage.

Certificate of Health Care Coverage (HIPAA Certificate)

Your Departmental Payroll/Personnel Assistant will provide a certificate of health care coverage to you and/or your covered family members if health care coverage ceases under the City's health care program. The certificate provides future employers and insurance providers with verification that you (and/or your covered dependents) had coverage under a City of Long Beach-sponsored plan.

Preexisting conditions of a new plan will then be reduced by one day for each day that you and/or your dependents had continuous health care coverage. Continuous health care coverage, including COBRA, means having no significant break (normally 63 or more days), immediately prior to the effective date of coverage under the new plan.

FLEXIBLE SPENDING ACCOUNTS

The Flexible Spending Accounts (FSA) are an effective way to increase your purchasing power for health and dependent care expenses. Available to all permanent full-time employees, these accounts let you use pretax dollars to pay eligible health and dependent care expenses you traditionally would pay out-of-pocket with after-tax dollars. The tax savings can really add up!

To participate, you must complete an enrollment form. A new election is required each year.

How These Accounts Work

How much do you spend each year for out-of-pocket health care and dependent care expenses? Your answer will help you decide how much, if any, of your pretax pay to set aside in each account.

You can contribute up to $3,600 annually to the Health Care Account, and/or up to $5,000 annually to the Dependent Care Account. Your contributions are deducted from your pretax pay in equal amounts throughout the plan year. Once you elect to participate, you cannot change or stop your contributions during the plan year unless you have a qualified status change.

Your contributions are deducted from your paycheck before taxes are withheld. This means you do not pay Social Security tax, federal income tax and, in most cases, state and local income tax on the amounts you set aside for eligible expenses.

Paying Expenses

When you have an eligible expense, you pay the expense and then submit a Reimbursement Request Form along with your receipts. Checks from the plan are issued weekly and mailed to your home.

Eligible Expenses

Eligible health care expenses are those not covered by other insurance plans, such as deductibles, copayments, coinsurance, prescription drugs, hearing care and vision expenses.

Eligible dependent care expenses are those that enable you (or you and your spouse, if you are married) to work or attend school full-time. They include daycare, preschool programs, and after school care for children under age 13. Eligible expenses also include elder care, or care for dependents of any age who are not capable of caring for themselves.

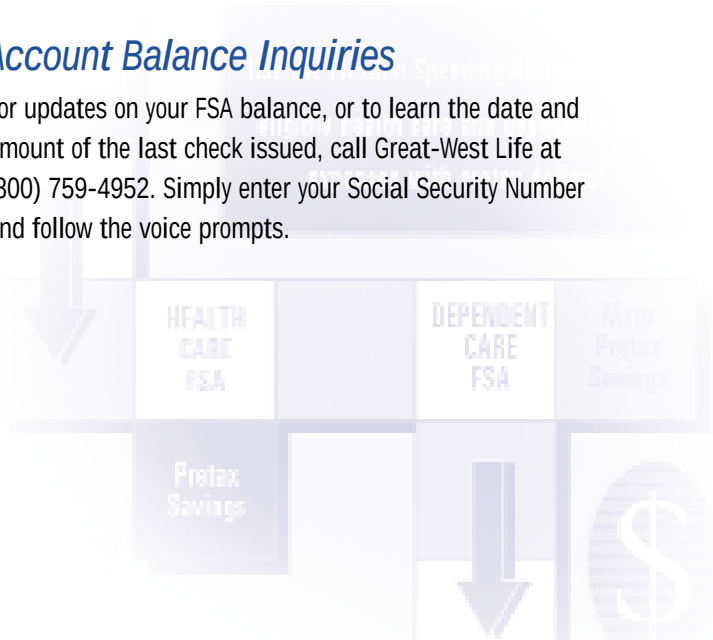
For more information on eligible expenses call the plan administrator, Great-West Life, at (800) 759-4952.

IMPORTANT!

Because of the special tax advantages, the IRS has a strict "Use It or Lose It" Rule that applies to these accounts. Any funds you contribute but do not use during the plan year for eligible expenses must be forfeited. You must estimate your expenses carefully.

Account Balance Inquiries

For updates on your FSA balance, or to learn the date and amount of the last check issued, call Great-West Life at (800) 759-4952. Simply enter your Social Security Number and follow the voice prompts.



2001-2002 OPEN ENROLLMENT Q&A SESSION SCHEDULE

Health and Dental Insurance Representatives

Representatives from each Health and Dental carrier will be available at these locations to provide information about their plans and answer questions.

1ST WEEK

MONDAY - OCTOBER 1

Parks, Rec. & Marine
Administration Building
Large Conf. Room
8:00 – 10:00 a.m.

Public Service
Training Center
Assembly Room
2:30 – 4:00 p.m.

TUESDAY - OCTOBER 2

Police Headquarters
Squad Room
7:00 – 9:00 a.m.

Health & Human Svcs.
Room 204
10:30 a.m. – 12:00 p.m.

Civic Center
Main Library Lower Level
1:30 – 3:30 p.m.

WEDNESDAY - OCTOBER 3

Water Dept. Treatment Plant
Assembly Room
7:00 – 9:00 a.m.

Harbor
Maintenance Yard
10:00 – 11:30 a.m.

Police West Station
Squad Room
1:30 – 3:30 p.m.

THURSDAY - OCTOBER 4

Long Beach
Energy Auditorium
7:00 – 9:30 a.m.

Harbor
Cafeteria Admin. Bldg.
10:30 a.m. – 12:30 p.m.

Police Headquarters
Squad Room
2:30 – 4:00 p.m.

FRIDAY - OCTOBER 5

Police East Station
Squad Room
7:00 – 9:00 a.m.

Civic Center
Main Library
Lower Level
11:00 a.m. – 1:30 p.m.

2ND WEEK

MONDAY - OCTOBER 8

Civic Center
Main Library Lower Level
11:30 a.m. – 1:30 p.m.

Health & Human Svcs.
Room 204
2:30 – 4:00 p.m.

TUESDAY - OCTOBER 9

Public Service
Training Center
Assembly Room
12:00 – 2:00 p.m.

Water Dept.Treatment
Plant
Assembly Room
3:00 – 4:30 p.m.

WEDNESDAY - OCTOBER 10

Long Beach Energy
Auditorium
7:00 – 9:30 a.m.

Integrated Resources
Assembly Room
10:30 a.m. – 12:00 p.m.

Police North Station
Squad Room
2:30 – 4:00 p.m.

THURSDAY - OCTOBER 11

Public Service
Training Center
Assembly Room
11:00 a.m. – 1:30 p.m.

Police Headquarters
Squad Room
2:30 – 4:00 p.m.

FRIDAY - OCTOBER 12

Retiree Meeting (see schedule)

Notice to Participants

New Federal laws impose certain requirements on group health plans. Under these new Federal laws, collectively referred to as HIPAA, a group health plan is limited in imposing pre-existing conditions; must offer employees and dependents the opportunity to enroll in the plan outside of open enrollment periods in certain situations; cannot discriminate on the basis of health status with respect to eligibility for plan participation and premium costs; cannot impose discriminatory lifetime or annual benefit limitations for participants with mental illness; and must permit hospital admissions (if otherwise covered by the plan) of at least 24 hours in the case of normal deliveries and 48 hours in the case of Cesarean Sections.

With respect to many of the above restrictions, the City of Long Beach is currently in compliance with State law requirements and many of the HIPAA requirements under Federal law. Further, the City of Long Beach does not discriminate on the basis of health status with respect to eligibility for health plan participation or premium costs.

As part of the new Federal law, plan sponsors of non-Federal government plans can elect to be exempt from the above-mentioned requirements. The City of Long Beach has elected exemption from HIPAA requirements for the plan year beginning December 1, 2001 and ending the following November 30, 2002.

Special Assistance

This Employee Benefit Summary information is available in an alternate format by request to the Department of Human Resources and Affirmative Action. If you need any special assistance or special materials to clearly and fully understand all of your benefit options, please call (562)570-6621. We would be more than happy to assist you in any way we can.